Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07800

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 88
HOSPITAL OR INSTITUTION OR STREET ADDRESS 501 Avirett Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 501 Avirett Avenue

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) none (Last) ADAMS
4. DATE OF DEATH (Month) 8 (Day) 9 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 1859 ?
9. AGE last birthday 91 yrs. If under 1 year Months. Days If under 24 hrs. Hours Mio.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Huey Jackson
14. MOTHER'S MAIDEN NAME Ellen (?) Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Bernard Adams 501 Avirett Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause	(a) Chronic myocarditis and myocardial degeneration	2 yrs
Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	3 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950, to Aug 9, 1950, that I last saw the deceased alive on Aug 9, 1950, and that death occurred at 5 P. m., from the causes and on the date stated above.

SIGNATURE R. W. Trevaskis, Sr (Degree or title) ADDRESS Cumberland, Md DATE SIGNED Aug 11 - 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Aug. 12, 50
NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery
LOCATION (City, town, or county) (State) Cumberland. Maryland

DATE REC'D BY LOCAL REG. Aug. 11, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

RECEIVED
AUG 15 1950
BUREAU V. S

Within corporate limit.

DR. W.F.WMS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

67801

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

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VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.
LENGTH OF STAY (in this place): 7 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: WEST VIRGINIA — COUNTY: Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ROMNEY, W.VA.
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) ISAAC (Middle) H. (Last) ALBRIGHT

4. DATE OF DEATH: (Month) AUG. (Day) 19 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: JUNE 6, 1887

9. AGE last birthday: 63 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: W.Va. Dairy (State School)

11. BIRTHPLACE (State or foreign country): W.VA.

12. CITIZEN OF WHAT COUNTRY: USA.

13. FATHER'S NAME: WILLIAM EDWARD ALBRIGHT

14. MOTHER'S MAIDEN NAME: ~~KATHERN HANNER~~ Hannah Katherine Hitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

421.4 **Immediate cause** (a) Chronic Myocardial Degeneration

92d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Chronic Endocarditis
(c) (Uremia)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-12-, 1950, to 8-19-, 1950, that I last saw the deceased alive on 8-19-, 1950, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

W.F. Williams M.D. | Cumberland | 8-19-50.

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Aug. 21, 1950 | NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery | LOCATION (City, town, or county) (State): Near Romney, W.Va.

DATE REC'D BY LOCAL REG.: Aug. 20, 1950 | REGISTRAR'S SIGNATURE: Winter F. Kantz, M.D. | 24. FUNERAL DIRECTOR: Merle Combs | ADDRESS: Romney W.Va.

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AUG 29 1950
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

67802

Reg. Dist. No. 04

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellerslie
LENGTH OF STAY (in this place) 25 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hyndman Rd

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
~~CITY~~ (If outside corporate limits, write RURAL and give nearest town) ~~OR~~ TOWN Ellerslie
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Christian (Last) Albright

4. DATE OF DEATH (Month) Aug (Day) 2 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH May 15 1871
9. AGE last birthday 79 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (Retired)
10b. KIND OF BUSINESS OR INDUSTRY Stationary-Pipeline
11. BIRTHPLACE (State or foreign country) Bedford Co Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel H Albright
14. MOTHER'S MAIDEN NAME Laura J Buchanan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Alice Caroline Albright (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X Immediate cause (a) Emmel Infection Jr Bed sores — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks

131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Nephritis — 2 mos. years

(c) Hypertensive Heart disease — second year

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1950, to Aug 2, 1950, that I last saw the deceased alive on Aug 1, 1950, and that death occurred at 1:10 A m., from the causes and on the date stated above.

SIGNATURE F. Alan G. Murray (Degree or title) MD ADDRESS Cumberland DATE SIGNED Md

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug 4 50
NAME OF CEMETERY OR CREMATORY Rose Hill Cem
LOCATION (City, town or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. August 3 1950
REGISTRAR'S SIGNATURE J. Lloyd Wolfe
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland Md

V16V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07803

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 2.1/2 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.Va COUNTY Grant
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Petersburg (rural)
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Andrew (Middle) (Last) Alt

4. DATE OF DEATH (Month) Aug. (Day) 15 (Year) 1950

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH June 20, 1872
9. AGE last birthday 78 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming. Own Farm
11. BIRTHPLACE (State or foreign country) West Virginia, Grant County
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME John Alt
14. MOTHER'S MAIDEN NAME Susan Blackwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
816.5 Immediate cause	(a) Intracranial hemorrhage due to a fractured skull	6 hrs
170c Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) also had several fractured left side of chest left femur fractured at surgical neck.	
	(c) Large scalp laceration of scalp	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) highway near (CITY OR TOWN) Petersburg (COUNTY) — (STATE) W.Va.
TIME OF INJURY (Month) Aug. (Day) 15/50 (Year) 9.30 A. m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Drove out on highway and was hit by a truck.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Aug.15-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 8/17/50
NAME OF CEMETERY OR CREMATORY Alt Cemeteries
LOCATION (City, town, or county) Near Petersburg (State) W.Va.

DATE REC'D BY LOCAL REG. Aug. 15, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR P. E. Thrush & Son ADDRESS Petersburg, West Virginia

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AUG 22 1950
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Lutheran 07804

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 183 E. Main St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GERSHON	M.	ANTHONY	Aug.	2,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	married	8-8-1883	66 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): civil engineer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gershon Anthony
14. MOTHER'S MAIDEN NAME: Rachel Llewellyn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Mrs. Mary Anthony, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Carcinomatosis stomach, liver, gall bladder.	1 month.
151X Antecedent cause(s)		
462 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) Carcinoma stomach.	18 months
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None.
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1950, to August 2, 1950, that I last saw the deceased alive on August 1, 1950, and that death occurred at 5:00 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A E Gatten	M. D.	167 E. Main St. Frostburg, Md.	8/2/50.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8-4-1950	Frostburg Mem'l Park	Frostburg,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-4-50	Mrs. Nancy N. Roe	J. R. Durst,	Frostburg, Md.

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RECEIVED
AUG 7 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07805

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) near Frostburg
LENGTH OF STAY (in this place): 4 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: About 1 mile north of route 40 on Big Savage Mt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Pa.; COUNTY: Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Myersdale
STREET ADDRESS (If rural give location): R.F.D.#3

3. NAME OF DECEASED (Type or Print): (First) Grant (Middle) Albert (Last) Baker

4. DATE OF DEATH: (Month) Aug. (Day) 30 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: May 5-1913

9. AGE last birthday: 37 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Skilled laborer

10b. KIND OF BUSINESS OR INDUSTRY: Making brick

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harvey E. Baker

14. MOTHER'S MAIDEN NAME: Margaret E. Shunk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-10-1292

17. INFORMANT: Hattie M. Baker (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Electrocusion (Accident)	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

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II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (rural) (CITY OR TOWN): Big Savage Mt. near Frostburg (COUNTY): Allegany (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 30/50 11.05 A.m.

INJURY OCCURRED While at work ☒ Not while at work ☐

HOW DID INJURY OCCUR? Removing dead electri line, came in contact with 12,000 vol live wire.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland, Md.	Aug 30-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-3-1950	Greenville Cemetery	Greenville, Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-1-50	Mrs. Nancy N. Rae	Wm Price, Meyersdale, Pa.	

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RECEIVED
SEP 5 1950
BUREAU V. S

Within corporate limits

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE PENNA COUNTY Somerset ~~GARRETT~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SALISBURY, rural
STREET ADDRESS (If rural, give location) R. F. D. #1

3. NAME OF DECEASED (Type or Print) (First) PAUL (Middle) J (Last) BEACHY

4. DATE OF DEATH (Month) AUGUST (Day) 29 (Year) 1950

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE

8. DATE OF BIRTH MAY 1, 1950

9. AGE last birthday yrs. If under 1 year Months 3 Days 28 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY Infant

11. BIRTHPLACE (State or foreign country) PENNA Somerset County

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME ALVIN BEACHY

14. MOTHER'S MAIDEN NAME RACHEL Beachy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS ALVIN BEACHY, SALISBURY, PENNA.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Virus Pneumonia (Left upper lobe)	1 week
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Congenital Heart (Enlarged)	Birth.
	(c)	

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II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/26, 1950, to 8/29, 1950, that I last saw the deceased alive on 8/28, 1950, and that death occurred at 4 A m., from the causes and on the date stated above.

SIGNATURE H A Eliason (Degree or title) ADDRESS 126 Union St. Cumberland Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Sept. 1, 1950

NAME OF CEMETERY OR CREMATORY Flag Run Cemetery

LOCATION (City, town, or county) (State) Somerset Co., Penna.

DATE REC'D BY LOCAL REG. Aug. 29, 1950

REGISTRAR'S SIGNATURE Walter L. Frantz, M.D.

24. FUNERAL DIRECTOR Wm Winterberg Grantsville ADDRESS

9-V 5-01-0-99-V-99-V

RECEIVED
SEP 6 1950
BUREAU V. S

Evidence for addition as shown in #18

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07807

CERTIFICATE OF DEATH

Reg. Dist. No. 10

FILM No. G 1 27 AUG 23 1950

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
BIRTIE	IRENE	BLACK	Aug.	2,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs Hours	Min.
female	white	married	4-11-1900	50 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	home	Mt. Savage, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William A. Kirby	Estella Crowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	none	Wm. H. Kirby, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

410 X **Immediate cause** (a) Mitral Stenosis — Interval Between Onset and Death: 5 years or more

92 b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Rheumatic Fever – Inactive (8/22/50 qms) — 9 years ago

(c) Extensive Edema town extremities

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from January, 1948, to August 2, 1950, that I last saw the deceased alive on August 2, 1950, and that death occurred at 11:15 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title) ADDRESS	DATE SIGNED
William E. Mosley	Mt Savage Md.	August 4-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-5-1950	Methodist Cemetery	Mt. Savage, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
August 4	Thomas B. Emmett	J. R. Durst,	Frostburg, Md.

RECEIVED
AUG 9 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07808

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 310 Williams Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 310 Williams Street

3. NAME OF DECEASED (Type or Print): (First) Ressie (Middle) Leona (Last) Blume

4. DATE OF DEATH: (Month) Aug (Day) 10 (Year) 19 50

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug 12 1896

9. AGE last birthday: 53 yrs. — If under 1 year: Months. Days. If under 24 hrs: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: House Wife

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Oliver Twigg

14. MOTHER'S MAIDEN NAME: Minnie Browning

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Frank Blume, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Ca carcinomatosis — Interval between onset and death: 6 mon

170X Antecedent cause(s)

50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Bilateral Carcinoma Breasts — 3 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1947

19b. MAJOR FINDINGS OF OPERATION: Ca carcinoma Breasts

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 19 50, to Aug 10, 19 50, that I last saw the deceased alive on Aug 9, 19 50, and that death occurred at 7:40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Clark L. Jarrett M.D. Cumberland 8/11/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Aug 12 1950 — NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Aug. 11, 1950 — REGISTRAR'S SIGNATURE: Walter K. Mantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: William H. Kight, Cumberland, Md.

RECEIVED
AUG 15 1950
BUREAU, F. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07809

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH
COUNTY Allegany County Md
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | MARYLAND | LENGTH OF STAY (in this place) 5 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Inf.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Alleg
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 217 Columbia St

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Cushman (Last) Burkholder

4. DATE OF DEATH (Month) Aug (Day) 23 (Year) 1950 — 5 PM

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower | 8. DATE OF BIRTH Nov 22 1883 | 9. AGE last birthday 66 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Butcher & Real Estate Dealer | 10b. KIND OF BUSINESS OR INDUSTRY Self Emp. | 11. BIRTHPLACE (State or foreign country) New Market Va. | 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Abraham Burkholder | 14. MOTHER'S MAIDEN NAME Ellen Cushman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT AND ADDRESS Infirmary records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334x Immediate cause (a) Apoplexy — Interval between onset and death: 2 days

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — (P)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 21, 1950, to Aug 23, 1950, that I last saw the deceased alive on Aug 21, 1950, and that death occurred at 6:25 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H. V. Denning M.D | Cumberland Md | Aug 23/1950

23. BURIAL, CREMATION / REMOVAL (Specify) Burial | DATE THEREOF Aug. 26, 1950 | NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery | LOCATION (City, town, or county) (State) New Market, Virginia

DATE REC'D BY LOCAL REG. Aug. 24, 1950 | REGISTRAR'S SIGNATURE Wynter K. Darby M.D. | 24. FUNERAL DIRECTOR D.B. Shea Jr. | ADDRESS New Market, Virginia

45261

VS. A15

4 2 93 M

Mrs Wm Steele
617 Columbia ave.

St Matthews Cemetary
Saturday - 2-PM

D. B. Theis Jr Funeral Home

RECEIVED
AUG 29 1950
BUREAU V. 3

Evidence for addition as shown in #21

FILM No. G 1 27 AUG 23 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07810

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gilmore
LENGTH OF STAY (In this place): 48 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gilmore
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Fredericka (Middle) Elizabeth (Last) Cadwallader

4. DATE OF DEATH: (Month) August (Day) 10 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb 26, 1873

9. AGE last birthday: 77 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Click

14. MOTHER'S MAIDEN NAME: Mary Cutter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT: Mrs Leo Cadwallader

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Hypostatic Pneumonia	2 ds.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Fracture leg — 900.0 186a	4 mo.
	(c) Arteriosclerotic Cardio-Vascular cerebral disease	(3)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home
(CITY OR TOWN): Gilmore (COUNTY): Alleg. (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): 4-12-50 m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? Fell down step (8-23-50 - ams)

22. I hereby certify that I attended the deceased from 8/10, 1950, to 8/10, 1950, that I last saw the deceased alive on 8/10, 1950, and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Paul Eugene Frye, M.D — ADDRESS: Lonaconing Md. — DATE SIGNED: 8/12/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Aug 13, 1950
NAME OF CEMETERY OR CREMATORY: Old Coney Cemetery
LOCATION (City, town, or county) (State): Lonaconing Md

DATE REC'D BY LOCAL REG. 8-13-50
REGISTRAR'S SIGNATURE: Jeannette M Boal

24. FUNERAL DIRECTOR: M. Eichhorn — ADDRESS: Lonaconing, Md.

RECEIVED
AUG 17 1950
BUREAU F. S

Within corporate limits

M

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07811

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 50 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural, give location) 601 Frederick St

3. NAME OF DECEASED (Type or Print) (First) Valentino (Middle) (Last) Cioni

4. DATE OF DEATH (Month) Aug (Day) 7 (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH July 13, 1879

9. AGE last birthday 71 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fruit Store Owner

10b. KIND OF BUSINESS OR INDUSTRY Selling Fruit

11. BIRTHPLACE (State or foreign country) Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT AND ADDRESS Anthony Cioni, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X Immediate cause (a) Hypertensive Heart Disease & Terminal Failure — INTERVAL BETWEEN ONSET AND DEATH 2 years

Antecedent cause(s)

61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis

(c) Diabetes mellitus

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arterial Hypertension

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1946, to 7 Aug, 1950, that I last saw the deceased alive on 7 Aug, 1950, and that death occurred at 4 P m., from the causes and on the date stated above.

SIGNATURE W. A. Van Ormer (Degree or title) ADDRESS Cumberland, Md DATE SIGNED 7 Aug. 50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Aug. 10, 1950

NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery

LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REG. Aug. 10, 1950

REGISTRAR'S SIGNATURE Winter K. Frantz M.D.

24. FUNERAL DIRECTOR William H. Kight Cumberland, Md. ADDRESS

15661

Van Ormer

RECEIVED
AUG 14 1960
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07812 6

Reg. Dist. No.

1. PLACE OF DEATH COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: McCoole — LENGTH OF STAY (in this place): 84 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: McCoole
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 70 Howard St	STREET ADDRESS (If rural, give location): 70 Howard St.,

3. NAME OF DECEASED (Type or Print)	(First) Isaac	(Middle) Fletcher	(Last) Clark	4. DATE OF DEATH	(Month) Aug. (Day) 1 (Year) 1950
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Oct. 2, 1865	9. AGE last birthday: 84 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Track Foreman (Retired)	10b. KIND OF BUSINESS OR INDUSTRY: W.Md. Ry. Co.	11. BIRTHPLACE (State or foreign country): 21st Bridge, Allegany Co.	12. CITIZEN OF WHAT COUNTRY? Md N.P.		
13. FATHER'S NAME: George W. Clark		14. MOTHER'S MAIDEN NAME: Mary Matheney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: Mrs. I. F. Clark			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocarditis with Pulmonary Oedema	3 days
422.1 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerosis.	
	(c) Prostate enlargement with obstruction	4 years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1946, to Aug 1st, 1950, that I last saw the deceased alive on Aug 1, 1950, and that death occurred at 7:28 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[signature]	M.D.	Keyser W.Va	8250

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 4/50	Dayton Cemetery near	McCoole, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 2/50	[signature] M.D.	B.W. Markwood	Keyser, W. Va

41847

RECEIVED
AUG 4 1950
BUREAU V. S

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07813

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Co. Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 206 Central Ave.

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) S (Last) Collins
4. DATE OF DEATH (Month) Aug (Day) 24 (Year) 1950

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower
8. DATE OF BIRTH Sept 9-1867
9. AGE last birthday 82 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired railroader
10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry
11. BIRTHPLACE (State or foreign country) Flintstone, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John S.Collins
14. MOTHER'S MAIDEN NAME Catherine Gordon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mrs John Malcolm

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremic coma due to	1 day
450.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Interstitial nephritis	?
131a	(c) Arteriosclerosis	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 12, 1950, to Aug 24, 1950, that I last saw the deceased alive on Aug 23, 1950 and that death occurred at 6.50 A.m., from the causes and on the date stated above.

SIGNATURE H.V.Deming M.D. (Degree or title) ADDRESS Cumberland, Md. DATE SIGNED 8-24-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 8/27/50 8/26
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Aug. 26 1950
REGISTRAR'S SIGNATURE Winter R. Fantz M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md. ADDRESS

~~Deputy Medical Examiner - Allegany Co.~~
Substituting for Dr. A. Jones.

10247

RECEIVED
AUG 28 1950
BUREAU V. S

Dr Davis
07814

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 21 Welsh St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
STREET ADDRESS (If rural, give location): 21 Welsh St.

3. NAME OF DECEASED (Type or Print) (First): THORNTON (Middle): S. (Last): COOPER
4. DATE OF DEATH (Month): Aug. (Day): 26, (Year): 1950

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 2-4-1881
9. AGE last birthday: 69 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired tailor
10b. KIND OF BUSINESS OR INDUSTRY: Tailor shop owner
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Cooper
14. MOTHER'S MAIDEN NAME: Margaret Seifker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: Mrs. Eleanor Cooper, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uremia

443X Antecedent cause(s)

93 di Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Congestive Heart Failure

(c) Hypertensive

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 24 Aug, 1950 to 26 Aug, 1950, that I last saw the deceased alive on 26 Aug, 1950, and that death occurred at 2 45 EST m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John B. Davis, MD.
ADDRESS: Frostburg, Md
DATE SIGNED: 8/29/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 8-29-1950
NAME OF CEMETERY OR CREMATORY: Frostburg Mem'l Park
LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 8-29-50
REGISTRAR'S SIGNATURE: Mrs Nancy H. Roe
24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

36006

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A1

RECEIVED
SEP 1 1950
BUREAU V. S

Within corporate limits

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07815

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 66 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 516 Avondale Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 516 Avondale Ave.

3. NAME OF DECEASED (Type or Print) (First) Mortimer (Middle) Sylvester (Last) Cosgrove

4. DATE OF DEATH (Month) Aug. (Day) 18 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH July 3, 1884

9. AGE last birthday 66 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician

10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp

11. BIRTHPLACE (State or foreign country) Cumberland, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Peter Cosgrove

14. MOTHER'S MAIDEN NAME Martha V. Judy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-4095

17. INFORMANT AND ADDRESS Mildred Ziler Cosgrove, 516 Avondale Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Failure	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocardial Infarction due to Coronary artery insufficiency	5 mos
	(c) Arteriosclerotic and Hypertensive Heart Disease	2 years

420.1
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) no (CITY OR TOWN) no (COUNTY) no (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) no m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? no

22. I hereby certify that I attended the deceased from 11/28, 1949, to Aug 18, 1950, that I last saw the deceased alive on Aug 12, 1950, and that death occurred at 1:00 P m., from the causes and on the date stated above.

SIGNATURE Aaville Ge Weisman MD (Degree or title) ADDRESS 59 Greene St Cumberland Md DATE SIGNED 8/18/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 8/21/50

NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park

LOCATION (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REG. Aug. 20, 1950

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md. ADDRESS

31416

RECEIVED
AUG 29 1950
BUREAU V. S

Davis

07816

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Potomac Park
LENGTH OF STAY (in this place): 21 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rt 6 Cumberland Md

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Potomac Park
STREET ADDRESS (If rural, give location): Rt 6 Cumberland Md

3. NAME OF DECEASED (Type or Print): (First) Arch (Middle) G. (Last) Davis

4. DATE OF DEATH: (Month) Aug (Day) 1 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 14, 1879

9. AGE last birthday: 71 yrs.

If under 1 year: Months | Days
If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Celanese Worker

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Frostburg Md

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Wm Davis

14. MOTHER'S MAIDEN NAME: Mary And Read.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Mary Davis, Rt. 6, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	1 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	
	(c)	

420.1
9da

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☐, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Benedict Sketarelic	M.D	Rt #2 Cumberland, Md.	8/1/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	August 4 1950	Hillcrest Cemetery	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug 4, 1950	M. H. Trump	John J. Hafer	Cumberland Md.

496 16

RECEIVED
AUG 10 1950
BUREAU F. S

07817

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Flintstone
LENGTH OF STAY (in this place) 6 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 1, Flintstone

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Flintstone
STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) (First) John (Middle) (Last) Day

4. DATE OF DEATH (Month) Aug (Day) 1 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed

8. DATE OF BIRTH Sept 3, 1868

9. AGE last birthday 81 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Self employed

11. BIRTHPLACE (State or foreign country) Timber Ridge, W. Va

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joshua Day

14. MOTHER'S MAIDEN NAME Christine Sites

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Mrs. Ora Vance Rt. 1, Flintstone, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Ruptured sclerotic vessel

(c)

331X

83a

INTERVAL BETWEEN ONSET AND DEATH 2 days.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 30, 1950, to August 1, 1950, that I last saw the deceased alive on Aug 1, 1950, and that death occurred at 9:00 P. m., from the causes and on the date stated above.

SIGNATURE Benedict Skitarelic (Degree or title) MD ADDRESS Rt #2 Cumberland, Md DATE SIGNED 8/3/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Aug 5, 1950

NAME OF CEMETERY OR CREMATORY Union Valley Cemetery

LOCATION (City, town, or county) Carroll Co. (State) Ohio

DATE REC'D BY LOCAL REG. Aug. 5, 1950

REGISTRAR'S SIGNATURE Nina L. Bender

24. FUNERAL DIRECTOR John J. Hofer ADDRESS Cumberland, Md.

000VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M

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RECEIVED
AUG 7 1950
BUREAU V. S

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07818

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Wills Mt.
MARYLAND
LENGTH OF STAY (in this place): about 3 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: near Cumberland, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 418 N. Mechanic St.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Lorenz (Last) Dickerhoof

4. DATE OF DEATH: (Month) Aug. 4 (Day) (Year) 19 50

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: June 30-1886

9. AGE last birthday: 64 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired sweeper, warp knitting, Celanese

10b. KIND OF BUSINESS OR INDUSTRY: Corp.

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Joseph Dickerhoof

14. MOTHER'S MAIDEN NAME: Anna Rank

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-6874

17. INFORMANT: Lelia B. Dickerhoof

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute cardiac failure due to over	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) exertion, coronary insufficiency	
	(c) coronary sclerosis	?

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland, Md.	Aug. 5-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	August 7 1950	Rose Hill Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 7, 1950	Hunter L. Kantz, M.D.	Louis Stein, Inc.	Cumberland, Md.

VS. A15A

496 16

RECEIVED
AUG 15 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

07819

2411 N. Charles Street, Baltimore

Dr. J. H. Wolverton

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport; LENGTH OF STAY (In this place): 75 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Stoney Run Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport; STREET ADDRESS (If rural, give location): Stoney Run Road

3. NAME OF DECEASED (Type or Print): (First) THURSEY (Middle) REBECCA (Last) DUCKWORTH

4. DATE OF DEATH: (Month) August (Day) 24 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: April 24, 1875

9. AGE last birthday: 75 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Westernport, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John E. Miller

14. MOTHER'S MAIDEN NAME: Mary Ellen Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No; (If year, give war or dates of service): - - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Ernest Martin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral arteriosclerosis	2 yrs
334 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 97	(b) Generalized arteriosclerosis	10 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED Whilo at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1950, to Aug 24, 1950, that I last saw the deceased alive on Aug 24, 1950, and that death occurred at 1:00 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James H. Wolverton Jr	M D	Piedmont W. Va	W. Va 8/26/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 26, 1950	Philos Cemetery	Westernport, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug 26/50	A Bazenbaker MD	E. S. Boal, Westernport, Md.	

RECEIVED
SEP 5 1950
BUREAU V. S

DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07820

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ELLERSLIE
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) LELIA (Middle) M. (Last) ENFIELD

4. DATE OF DEATH: (Month) AUG. (Day) 15 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH: FEB. 26 1888

9. AGE last birthday: 62 yrs.

If under 1 year: Months / Days

If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN SCARBOROUGH

14. MOTHER'S MAIDEN NAME: MARY WINSOR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 8-12-50

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Malignant Hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-12-50, 1950, to 8-15-50, 1950, that I last saw the deceased alive on 8-15-50, 1950, and that death occurred at 3:10 P m., from the causes and on the date stated above.

SIGNATURE: W. F. Williams (Degree or title) M.D. ADDRESS: Cumberland DATE SIGNED: 8-16-50.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 8-17-1950

NAME OF CEMETERY OR CREMATORY: HillCrest Cem.

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Aug. 17 1950

REGISTRAR'S SIGNATURE: Winter K Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

Mr. Geo

RECEIVED
AUG 22 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

017821

Reg. Dist. No. 4

M

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 500 Magruder St.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

3. NAME OF DECEASED (Type or Print): (First) Leslie (Middle) William (Last) Fair

4. DATE OF DEATH: (Month) Aug. (Day) 22, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 9-10-1899

9. AGE last birthday: 50 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Tire

11. BIRTHPLACE (State or foreign country): Mt. Savage, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George C. Fair

14. MOTHER'S MAIDEN NAME: Ella Nora Hutzell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-07-0787

17. INFORMANT AND ADDRESS: Mrs. Isabell Fair Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebro vascular accident — Interval between onset and death: 36 hr

E30 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 21, 1950, to Aug 22, 1950 that I last saw the deceased alive on Aug 22, 1950, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George M Lemmon M.D Cumberland Md 8/23/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 8-25-1950

NAME OF CEMETERY OR CREMATORY: St. Michael's

LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: Aug 24, 1950

REGISTRAR'S SIGNATURE: Wirtes L Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

3/6 35

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Evidence for addition as shown in #21

FILM No. G 127 SEP 7 1950

FILM No. G 127 AUG 23 1950

Dr. Murray

07822

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place): 2 wks	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First) MICHAEL	(Middle) HENRY	(Last) FANNON	4. DATE OF DEATH	(Month) August (Day) 9, (Year) 1950
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married	8. DATE OF BIRTH: 3-14-1882	9. AGE last birthday: 68 yrs.	If under 1 year: Months. Days; If under 24 hrs: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): loading foreman	10b. KIND OF BUSINESS OR INDUSTRY: Brick plant	11. BIRTHPLACE (State or foreign country): Mt. Savage, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Edward Fannon	14. MOTHER'S MAIDEN NAME: Ellen Cunningham				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 214-01-0144	17. INFORMANT AND ADDRESS: Mrs. Nellie Fannon, Mt. Savage, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	2 weeks
331x Antecedent cause(s)	Fall and probably stunde head	
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Causing rupture Blood vessel	
	(c) Reide Hemiplegia	

Hemiplegia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) ✓ — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Brickyard — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) July 26, 1950 m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR? Was found unconscious on floor near steps, with a Resided paralysis (8/22/50 A.S.)

22. I hereby certify that I attended the deceased from July 26 1950, to Aug 9, 1950, that I last saw the deceased alive on Aug 9, 1950, and that death occurred at 12:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

F. Alan G. Murray M.D. Cumberland Md 8-10-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 8-12-1950	NAME OF CEMETERY OR CREMATORY: St. Patricks Cemetery	LOCATION (City, town, or county) (State): Mt. Savage, Md.
DATE REC'D BY LOCAL REG.: 8-11-50	REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe	24. FUNERAL DIRECTOR: J. R. Durst,	ADDRESS: Frostburg, Md.

31627

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 15 1950
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07823

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 15

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Dawson
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 220 near Big Rock Service Station

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.Va. COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Keyser
STREET ADDRESS (If rural give location) 484 South Water St.

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) J. (Last) Gardner
4. DATE OF DEATH (Month) Aug (Day) 30 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH Dec.25-1914
9. AGE last birthday 35 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman
10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.
11. BIRTHPLACE (State or foreign country) New Creek, W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Clarence E.Gardner
14. MOTHER'S MAIDEN NAME Nellie V.Junkins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.2
16. SOCIAL SECURITY No.
17. INFORMANT Mrs.T.P.Liller (sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary hemorrhage due to punctured

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) lung from fractured ribs left side of chest.

(c) fractures of left arm & pelvis.

INTERVAL BETWEEN ONSET AND DEATH about 5 minutes

816.5
170 C

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) route 220
(CITY OR TOWN) Dawson (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) Aug. (Day) 30/50 (Year) 512 (Hour) P. m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Hit oil truck lost control of his automobile.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Aug.31-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9-2-50
NAME OF CEMETERY OR CREMATORY Queenspoint Cemetery
LOCATION (City, town, or county) (State) Keyser, W. Va.
DATE REC'D BY LOCAL REG. 9/21/50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Rogers Funeral Home ADDRESS Keyser, W. Va.

41847

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 5 1950
BUREAU V. S

Outside of City Limits

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15A

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MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07824

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone Near Cumberland, Rural
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.#2, Breakneck Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Cumberland Rural Flintstone
STREET ADDRESS (If rural give location) R.F.D.#2, Breakneck Road

3. NAME OF DECEASED (Type or Print) (First) Arnold (Middle) (Last) Hall

4. DATE OF DEATH (Month) Aug. (Day) 5 (Year) 1950

5. SEX Male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH June 12-1868

9. AGE last birthday 82 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming

10b. KIND OF BUSINESS OR INDUSTRY general farming

11. BIRTHPLACE (State or foreign country) Petersburg, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Hall

14. MOTHER'S MAIDEN NAME Kate Keplinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs. Arnold Hall

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary tuberculosis with	?
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) pulmonary hemorrhage	about 5 minutes
	(c)	

002X

13b

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V. Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Aug. 5-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Aug. 7, 1950 NAME OF CEMETERY OR CREMATORY Glendale Brethern Cem LOCATION (City, town, or county) Near Flintstone Md. (State)

DATE REC'D BY LOCAL REG. Aug. 7, 1950 REGISTRAR'S SIGNATURE Winter K. Frantz, M.D. 24. FUNERAL DIRECTOR John J. Kafer, Cumberland, Md. ADDRESS

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AUG 15 1960
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07825

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS in his automobile at 400 N.Center St.	STREET ADDRESS (If rural give location) 811 Bedford St.

3. NAME OF DECEASED (Type or Print)	(First) Paul	(Middle)	(Last) Heuer	4. DATE OF DEATH	(Month) Aug	(Day) 28	(Year) 1950
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug.23-1880	9. AGE last birthday 70 yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr.of Job Printing	10b. KIND OF BUSINESS OR INDUSTRY business		11. BIRTHPLACE (State or foreign country) Hanover,Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Gottlieb Heuer			14. MOTHER'S MAIDEN NAME Gertrude Heppe				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None.	17. INFORMANT Gertrude S. Heuer				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

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Immediate cause (a) Coronary thrombosis with myocardial infarct at once

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis about 5 yr

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D.	H.V.Deming M.D.	Cumberland,Md.	Aug 28-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 30,1950	St. Lukes Cem.	Cumberland Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 29, 1950	Winter L. Frantz, M.D.	Louis Stein Inc.	" "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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SEP 6 1950
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH 07826

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland	LENGTH OF STAY (In this place) 37 Years
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural, give location) 328 Pear Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Amos	Milton	Hixson	Aug	14	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs: Hours	Min.
Male	White	Married	April 22 1874	76 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Proprietor Service Station	Gasoline	Crystal Springs, Pa	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Nathan Hixson	Unknown Barton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	220-16-6949	Mrs Alice Hixson, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X **Immediate cause** (a) Carcinoma Right Lung — Interval Between Onset and Death: 6 mo.

47d **Antecedent cause(s)**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from July 1, 1950, to Aug 14, 1950, that I last saw the deceased alive on Aug 14, 1950, and that death occurred at 7-40 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
John A Topper MD	Hyattsville Md	8/15/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 17 1950	Hill Crest Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 17, 1950	Walter R. Hantz, M.D.	William H. Kight	Cumberland, Md.

VS. A15

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RECEIVED
AUG 22 1960
BUREAU W. S

Within corporate limits

07827

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 119 South Liberty St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 502 Fayette St.

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Alden (Last) Huster
4. DATE OF DEATH (Month) Aug. (Day) 9 (Year) 1950
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH Sept.12-1878
9. AGE last birthday 71 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer Retired Chief Judge
10b. KIND OF BUSINESS OR INDUSTRY Practice of Law
11. BIRTHPLACE (State or foreign country) Centerville Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William G. Huster
14. MOTHER'S MAIDEN NAME Rebecca Hite
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) W.W.1 Yes (If yes, give war, or dates of service) W.W.1 and Mexican War.
16. SOCIAL SECURITY NO. None
17. INFORMANT Earl Manges

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Coronary sclerosis	?
	(c)	Angina Pectoris	11 yrs.

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Aug 9-1950

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF AUG-11-1950
NAME OF CEMETERY OR CREMATORY BETHEL CEM
LOCATION (City, town, or county) (State) Rezzo Bedford Co Pa.
DATE REC'D BY LOCAL REG. Aug. 10, 1950
REGISTRAR'S SIGNATURE Winter R. Hanks M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland Md

25693

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 15 1950
BUREAU V. S

Within corporate limits

DR. SIMONS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07828

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 16 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL
MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 201 BALTIMORE ST. CUMBERLAND

3. NAME OF DECEASED (Type or Print): (First) FRANK (Middle) S. (Last) JOHNSON

4. DATE OF DEATH: (Month) AUG. (Day) 31 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: FEB 2, 1883

9. AGE last birthday: 67 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Union News Co.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JOSEPH JOHNSON

14. MOTHER'S MAIDEN NAME: YANTZ, MARY ALICE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-10-9016

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
153X Immediate cause	(a) Pulmonary Infarct	2 hr
46.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Thrombosis	1 year
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 19 50, to Aug. 31, 19 50, that I last saw the deceased alive on Aug 30, 19 50, and that death occurred at 6:20 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title): George M Simons M.D. ADDRESS: Cumberland Md DATE SIGNED: 8/31/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Sept 2, 1950
NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Sept. 2, 1950
REGISTRAR'S SIGNATURE: Walter L. Dantz, M.D.

24. FUNERAL DIRECTOR: John J. Hafer, Cumberland, Md.
ADDRESS

26614

RECEIVED
SEP 6 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07829

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 122 Hanover St.

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Joseph (Last) Jones

4. DATE OF DEATH (Month) Aug. (Day) 1 (Year) 1950

5. SEX Male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married
8. DATE OF BIRTH Sept. 6-1889
9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler maker
10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.
11. BIRTHPLACE (State or foreign country) Fort Supply, Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Jones
14. MOTHER'S MAIDEN NAME Mary A. Bride

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 705-05-5526
17. INFORMANT Hospital record.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary occlusion	at once
94a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	?
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. H.V. Deming M.D. (Degree or title) ADDRESS Cumberland, Md. DATE SIGNED Aug. 2-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug. 4, 1950
NAME OF CEMETERY OR CREMATORY St. Patricks
LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REG. Aug. 3, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR H. Wayne George ADDRESS Cumberland, Md.

30447

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 9 1950
BUREAU V. S

DR. SIMONS

Within corporate limits?

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07830 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (in this place) 5 DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; STREET ADDRESS (If rural, give location) 708 LOUISIANA AVENUE

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) E. (Last) KEECH Jr.

4. DATE OF DEATH: (Month) AUGUST (Day) 2, (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: SEPT. 20, 1882

9. AGE last birthday: 67 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired DRUGGIST

10b. KIND OF BUSINESS OR INDUSTRY: Owner - Drug Store

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES E. KEECH

14. MOTHER'S MAIDEN NAME: ELLEN COONEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X **Immediate cause** (a) Rectal Hemorrhage — Interval Between Onset and Death: 4 days

46a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma Sigmoid — 2 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1949, to August, 1950, that I last saw the deceased alive on August 1, 1950, and that death occurred at 3:35 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George M Symons M.D. ADDRESS 128 Mount St Cumberland Md DATE SIGNED 8/2/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 8/5/50 | NAME OF CEMETERY OR CREMATORY: St. Mary's Cem. | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Aug 3, 1950 | REGISTRAR'S SIGNATURE: Walter L. Kantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS: Cumberland, Md.

V30 70

RECEIVED
AUG 9 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07831

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 108 Main St	STREET ADDRESS (If rural, give location): 108 Main st.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Carrie Hedrick Keller	4. DATE OF DEATH (Month) (Day) (Year) 19: Aug. 14 1950
5. SEX: Female — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed — 8. DATE OF BIRTH: Oct. 12, 1879	9. AGE last birthday: 70 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife — 10b. KIND OF BUSINESS OR INDUSTRY: own home	11. BIRTHPLACE (State or foreign country): Piedmont, W. Va. — 12. CITIZEN OF WHAT COUNTRY? U.R.
13. FATHER'S NAME: George Klencke	14. MOTHER'S MAIDEN NAME: Anna Klencke
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) — 16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS: Robert Keller, Westernport, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
155X Immediate cause	(a) Obstruction common bile duct.	3 wo
Antecedent cause(s) 46f Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Adenocarcinoma involving gall bladder & common bile duct.	6 wo
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1950, to Aug 14, 1950, that I last saw the deceased alive on Aug 14, 1950, and that death occurred at 4:00 a m., from the causes and on the date stated above.

SIGNATURE: James H. Wolverton Jr. (Degree or title): MD ADDRESS: Piedmont W. Va DATE SIGNED: 8-15-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Aug. 16, 1950	NAME OF CEMETERY OR CREMATORY: Philos Cemetery	LOCATION (City, town, or county) (State): Westernport, Md.
DATE REC'D BY LOCAL REG: Aug. 16/50	REGISTRAR'S SIGNATURE: [illegible] MD	24. FUNERAL DIRECTOR: W. Harold Fredlock	ADDRESS: Piedmont, W. Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 17 1950
BUREAU

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07832

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 75 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmy

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 230 Oldtown Rd.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) J. (Last) Kelley

4. DATE OF DEATH: (Month) 8/28/50 (Day) (Year) 19

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: July 4, 1775

9. AGE last birthday: 75 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern Keeper

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Kelley

14. MOTHER'S MAIDEN NAME: Martha Drenning

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Wm. E. Kelley Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
420.1	Immediate cause	(a) Myocardial Failure	32 days
94a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	2 yrs
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29, 1950, to Aug 28, 1950, that I last saw the deceased alive on Aug. 28, 1950, and that death occurred at 1 45 p.m., from the causes and on the date stated above.

SIGNATURE: Arthur F. Jones (Degree or title) M.D. ADDRESS: 110 S. Centre St. DATE SIGNED: Aug. 28, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 8/31/50

NAME OF CEMETERY OR CREMATORY: St Mary's Cem.

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Aug. 29, 1950

REGISTRAR'S SIGNATURE: Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS: Cumberland, Md.

156 '11

VS-A15

RECEIVED
SEP 6 1950
BUREAU V. S

DR. FAW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07833

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY GRANT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 9	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CABINS, W. VA.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print): (First) ARVELLA (Middle) (Last) KILE

4. DATE OF DEATH: (Month) AUG (Day) 4 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH: APRIL 9, 1903

9. AGE last birthday: 47 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MARKWOOD, JAMES

14. MOTHER'S MAIDEN NAME: HULL, CORA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

153X Immediate cause (a) Myocardial failure, acute

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Laparotomy - Carcinoma of intestine

46 e (c) Probably cause - metastases to root of mesentery and intestinal obstruction

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myocardial insufficiency — 2 years

19a. DATE OF OPERATION: Aug 1, 1950

19b. MAJOR FINDINGS OF OPERATION: metastatic carcinoma to root of mesentery - intestinal obstruction

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29, 1950, to Aug 4, 1950, that I last saw the deceased alive on Aug 4, 1950, and that death occurred at 12:45 A.M. from the causes and on the date stated above.

SIGNATURE: Wylie M Faw Jr (Degree or title) M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: Aug 6, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 8/6/50 — NAME OF CEMETERY OR CREMATORY: Corner — LOCATION (City, town, or county) (State): Grant Co. W Va

DATE REC'D BY LOCAL REG.: Aug. 6, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Earl Bush, Petersburg, W. Va. — ADDRESS: Per Roscoe Halterman

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 15 1950
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

07834

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland
LENGTH OF STAY (in this place) 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.#2 Williams Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural) Cumberland
STREET ADDRESS (If rural give location) R.F.D.#2 Williams Road

3. NAME OF DECEASED (Type or Print) (First) Barbara (Middle) Gean (Last) Kinser
4. DATE OF DEATH (Month) Aug. (Day) 22 (Year) 1950
5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH Aug 8-1950
9. AGE last birthday 0 yrs. If under 1 year Months 0 Days 14 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY Infant
11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Lundy Kinser
14. MOTHER'S MAIDEN NAME Barbara Loretta Field
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Henry James

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH about 2 days

500X Immediate cause (a) Acute tracheal bronchitis

106a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Aug. 22-1950

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 8/23/50
NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.
LOCATION (City, town, or county) Cumberland, Md (State)
DATE REC'D BY LOCAL REG. Aug. 22, 1950
REGISTRAR'S SIGNATURE Winter R. Lantz M.D.
24. FUNERAL DIRECTOR James F. Scarfelli ADDRESS Cumberland, Md.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct date is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 29 1950
BUREAU V. S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07835

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital; MARYLAND; LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 314 Maryland Ave.

3. NAME OF DECEASED (Type or Print): (First) Laura (Middle) Virginia (Last) Kiser

4. DATE OF DEATH: (Month) Aug. (Day) 14 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 8-17-1867

9. AGE last birthday: 82 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph McELFish

14. MOTHER'S MAIDEN NAME: un Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Allegany Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
443X Immediate cause	(a) Cerebral Hemorrhage	3 mths.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Hypertensive C.V. Disease	years
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jany, 1949, to Augt 14, 1950, that I last saw the deceased alive on Augt 14, 1950, and that death occurred at 2:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): B. M. Schindler M.D. | ADDRESS: 41 Locust St, Cumberland, Md | DATE SIGNED: Aug 16/1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 8-18-50 | NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery | LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REG.: Aug. 17, 1950 | REGISTRAR'S SIGNATURE: Wm. L. Lantz, M.D. | 24. FUNERAL DIRECTOR: Louis Stein, Inc. | ADDRESS: Cumberland, Maryland

RECEIVED
AUG 22 1960
BUREAU W.. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07836

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (In this place): 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Corriganville
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Clarence (Middle) A. (Last) Lapp
4. DATE OF DEATH: (Month) Aug. (Day) 6 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: Sept. 11-1898
9. AGE last birthday: 51 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender
10b. KIND OF BUSINESS OR INDUSTRY: Saloon
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Conrad Lapp
14. MOTHER'S MAIDEN NAME: Martha Everline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-05-8511
17. INFORMANT: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
334X Immediate cause	(a) Bronchopneumonia (bilateral)	7 days
107 ? Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral edema (marked)	about 7 days
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title): H.V. Deming M.D. — ADDRESS: H. V. Deming M.D. Cumberland, Md. — DATE SIGNED: Aug. 7-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Aug. 9, 1950 | NAME OF CEMETERY OR CREMATORY: Porter Cemetery | LOCATION (City, town, or county) (State): Hyndman, Pa. RD1

DATE REC'D BY LOCAL REG.: Aug. 9, 1950 | REGISTRAR'S SIGNATURE: Walter L. Frantz, M.D.

24. FUNERAL DIRECTOR: Hyndman, Pa. — ADDRESS: Harvey H. Engle

20071

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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AUG 15 1960
BUREAU V. S

DR. SIMONS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

17837

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (in this place) 2 HRS. 45 MIN.; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, Rural; STREET ADDRESS (If rural, give location) BOX 155 LA VALE

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	CHARLES	William	LASHORN		AUGUST	5	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	MARRIED	SEPT. 18 1896	53 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Grocery Store	WEST VIRGINIA	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOSEPH R. LASHORN	MATILDA DORSEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO	217-05-0115	MEMORIAL AVE., MEMORIAL HOSPITAL, CUMBERLAND MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebro-vascular accident	3 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	3 years
	(c) Myocardial degeneration	2 years

443 X 33d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Nov., 1948, to August 5, 1950, that I last saw the deceased alive on 8/5, 1950, and that death occurred at 6:45 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
George M Simons M.D.	12 Union St Cumberland Md	8/6/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 8 1950	St Peters Cemetery	Westernport, Maryland.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 7 1950	Walter L. Beatty, M.D.	William H. Kight	Cumberland, Md.

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AUG 11 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07839/6 Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport, | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 120 Church Street.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport,
STREET ADDRESS (If rural, give location) 120 Church Street.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) (Last) Martin.

4. DATE OF DEATH (Month) (Day) (Year): Aug. 24, 1950. 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 2-18-1866

9. AGE last birthday: 84 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired. Clover

10b. KIND OF BUSINESS OR INDUSTRY: Marble works

11. BIRTHPLACE (State or foreign country): Hampshire, West Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Martin.

14. MOTHER'S MAIDEN NAME: Catherine Johnson.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Lola Martin.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Edema	1 Day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis and Myocardial Degeneration not Specified as Rheumatic	5 Years
422.1 93d	(c) Arterio-Sclerosis	5 Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 13, 1950, to Aug. 24, 1950, that I last saw the deceased alive on Aug. 24, 1950, and that death occurred at 10:55 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul R. Wilson	M.D.	Piedmont, W. Va.	Aug. 25, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-27-50	Philos Cemetery,	Westernport, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/27/50	A. Gaither Baker M.D.	W. Harvey Fredlock	Piedmont, W. Va.

156 V6

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SEP 5 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07840

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 5 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg, Md.
STREET ADDRESS (If rural, give location) 58 Tarn Terrace

3. NAME OF DECEASED (Type or Print): (First) Mollie (Middle) K, (Last) Mays
4. DATE OF DEATH: (Month) 8 (Day) 4 (Year) 1950

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W
8. DATE OF BIRTH: Oct 6, 1868
9. AGE last birthday: 81 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Maryland, Grantsville
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Keller
14. MOTHER'S MAIDEN NAME: Amanda Chapman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs May Lewis, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial failure — 6 wks

420.1 Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
94a (b) Coronary sclerosis — 2 yrs
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1946, to Aug. 4, 1950, that I last saw the deceased alive on Aug 1, 1950, and that death occurred at 5:30 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Arthur F. Jones M.D. 110 S. Centre St. Aug. 5, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: Aug 6, 1950
NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Aug. 6, 1950
REGISTRAR'S SIGNATURE: Walter K. Frantz, M.D.
24. FUNERAL DIRECTOR: John J. Nafer, ADDRESS: Cumberland, Md

RECEIVED
AUG 15 1930
BUREAU T. S.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07841

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke
LENGTH OF STAY (in this place) one week
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westvaco Club pool

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE N.Y. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New York, City
STREET ADDRESS (If rural give location) 220 East 82nd. St.

3. NAME OF DECEASED (Type or Print) (First) James (Middle) B. (Last) Mc Auliffee
4. DATE OF DEATH (Month) Aug. (Day) 12 (Year) 1950
5. SEX Male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH May-21-1923
9. AGE last birthday 27 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil engineer
10b. KIND OF BUSINESS OR INDUSTRY Surveying
11. BIRTHPLACE (State or foreign country) Oyster Bay, L.I., N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Mc Auliffee
14. MOTHER'S MAIDEN NAME Anna ----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.2
16. SOCIAL SECURITY NO. 130-24-9279
17. INFORMANT Nicholas Herko

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Asphyxia due to drowning	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

929.4
183

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Westvaco pool (CITY OR TOWN) Luke (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Aug. 12/50 2.50 P. m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Bathing in pool & drowned.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V. Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Aug-12-1950

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF 8-13-50
NAME OF CEMETERY OR CREMATORY Brookville Cemetery
LOCATION (City, town, or county) Oysterbay, Long Island (State) N.Y.
DATE REC'D BY LOCAL REG. Aug. 13/50
REGISTRAR'S SIGNATURE [illegible] M.D.
24. FUNERAL DIRECTOR W. Harold Fredlock ADDRESS Piedmont Wva

V1693

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AUG 15 1950
BUREAU V. S

Within corporate limits

DR. GROVE

07842

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) JOSEPH (Middle) P. (Last) MC CORMICK
4. DATE OF DEATH (Month) AUG. (Day) 16 (Year) 1950
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH NOV. 16/869
9. AGE last birthday 80 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trial Magistrate
10b. KIND OF BUSINESS OR INDUSTRY Court
11. BIRTHPLACE (State or foreign country) MARYLAND, Barton
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH MC CORMICK
14. MOTHER'S MAIDEN NAME JANE MATHESON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma of pharynx (left side)	2 mo.
148 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 45 f	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arterio sclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-14, 1950, to 8-16, 1950 that I last saw the deceased alive on 8-16, 1950 and that death occurred at 8:20P m., from the causes and on the date stated above.

SIGNATURE S. B. Irvine (Degree or title) M. D. ADDRESS Cumberland Md DATE SIGNED 8-17-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug 19, 1950
NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery
LOCATION (City, town, or county) (State) Moscow Allegany Co.
DATE REC'D BY LOCAL REG. Aug. 18, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz M. D.
24. FUNERAL DIRECTOR E. S. Bose Westerville Pvt. ADDRESS Md.

V2698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 22 1930
BUREAU W. 38

Within corporate limits

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07838

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 3 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Savage
STREET ADDRESS (If rural, give location) Railroad St

3. NAME OF DECEASED (Type or Print) (First) Bertha (Middle) Matilda (Last) Martin

4. DATE OF DEATH (Month) Aug (Day) 24 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Aug. 19, 1897
9. AGE last birthday 53 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rerolling Finers
10b. KIND OF BUSINESS OR INDUSTRY Kelly Springfield Tire
11. BIRTHPLACE (State or foreign country) Mt Savage Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Wm H. Carter
14. MOTHER'S MAIDEN NAME Carrie Kerns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-9907
17. INFORMANT AND ADDRESS Robt Carter - 311 Polk St - Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of uterus.

174X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

48b

(c) Metastasis to retroperitoneal glands.

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 8/23/50
19b. MAJOR FINDINGS OF OPERATION Extensive carcinoma of uterus -
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/1, 1950, to 8/25, 1950, that I last saw the deceased alive on 8/24, 1950, and that death occurred at 1 m., from the causes and on the date stated above.

SIGNATURE John R Rogum MD (Degree or title) ADDRESS Cumberland Md DATE SIGNED 8/25/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug 26 1950
NAME OF CEMETERY OR CREMATORY Mt Savage Methodist
LOCATION (City, town, or county) Mt Savage (State) Md

DATE REC'D BY LOCAL REG. Aug. 26, 1950
REGISTRAR'S SIGNATURE Arnter L. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hofer - Cumberland Md ADDRESS

48635

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 29 1950
BUREAU

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

67843

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland
LENGTH OF STAY (In this place) 33
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.#3 Bedford Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland
STREET ADDRESS (If rural give location) R.F.D #3 Bedford Road

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Walter (Last) Miller
4. DATE OF DEATH (Month) Aug. (Day) 23 (Year) 1950
5. SEX Male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Dec.8-1916
9. AGE last birthday 33 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal worker
10b. KIND OF BUSINESS OR INDUSTRY Installing Furnaces
11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Boyd H. Miller
14. MOTHER'S MAIDEN NAME Clara V. Hager
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 2nd World
16. SOCIAL SECURITY NO. 217-10-5268
17. INFORMANT Shirley Dermer Miller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Electrocution (accidental) — INTERVAL BETWEEN ONSET AND DEATH: at once

914.0

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

193

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [X] CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) near home
(CITY OR TOWN) rural Cumberland (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Aug.23/50 2.50 P. m.
INJURY OCCURRED While at work [X] Not while at work [ ]
HOW DID INJURY OCCUR? Using ungrounded electric drill.

22. *I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Aug.24-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug 26 1950
NAME OF CEMETERY OR CREMATORY Zion Memorial Burial
LOCATION (City, town, or county) (State) Park Cumberland, Md.

DATE REC'D BY LOCAL REG. Aug. 26, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR William H. Kight, ADDRESS Cumberland, Md.

36273

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 29 1950
BUREAU V. S

Within corporate limits

Richard Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07844

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 60 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1614 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 1614 Bedford St.

3. NAME OF DECEASED (Type or Print) (First) Richard (Middle) Hugh (Last) Miller

4. DATE OF DEATH (Month) Aug (Day) 1 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH February 17, 1870

9. AGE last birthday 80 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck gardener

10b. KIND OF BUSINESS OR INDUSTRY Self employed

11. BIRTHPLACE (State or foreign country) Graysville, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Miller

14. MOTHER'S MAIDEN NAME Elizabeth Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS Mrs. Richard H. Miller, 1614 Bedford St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Failure

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Myocarditis

(c)

INTERVAL BETWEEN ONSET AND DEATH: 2 months

4222

932

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1/10/49, 19....., to 8/1/50, 19....., that I last saw the deceased alive on 7/31/50, 19....., and that death occurred at 6 a m., from the causes and on the date stated above.

SIGNATURE H. Williams (Degree or title) ADDRESS M.D. DATE SIGNED 8/3/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF August 3, 1950

NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park

LOCATION (City, town, or county) Cumberland, (State) Md

DATE REC'D BY LOCAL REG. Aug. 3, 1950

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer, Cumberland, ADDRESS Md

000VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Mr. R. J. Weiss

RECEIVED
AUG 9 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07845

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 1 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 215 Virginia Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 215 Virginia Ave.

3. NAME OF DECEASED (Type or Print): (First) Samuel (Middle) Franklin (Last) Mock

4. DATE OF DEATH: (Month) Aug. (Day) 10 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec 12-1900

9. AGE last birthday: 49 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer - B&O R.Ry

10b. KIND OF BUSINESS OR INDUSTRY: round house

11. BIRTHPLACE (State or foreign country): Loysburg Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David G. Mock

14. MOTHER'S MAIDEN NAME: Ida M Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W -1

16. SOCIAL SECURITY NO.: 175-16-8935

17. INFORMANT: wife) Grace Roberts Mock

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☐, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland, Md. Aug.10-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 8/12/50 | NAME OF CEMETERY OR CREMATORY: Allegany Memorial Park | LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: Aug. 11, 1950 | REGISTRAR'S SIGNATURE: Walter L. Lantz M.D. | 24. FUNERAL DIRECTOR: James T. Scarpelli | ADDRESS: Cumberland Md.

98847

RECEIVED
AUG 15 1950
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07846

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Barton; HOSPITAL OR INSTITUTION OR STREET ADDRESS: ; MARYLAND LENGTH OF STAY (In this place): 40 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Barton; STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ellie	Mae	Moore	Aug.	23	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	Jan. 3-1882	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		White Pine, W.Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry C. Shimer	Mary Ayres

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	----	Leonard Moore

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
422.2	Immediate cause	(a) Acute cardiac failure due to	10 min.
93.2	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocarditis	5 yrs.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H. V. Deming M.D. H. V. Deming M.D.		Cumberland, Md.	Aug. 24-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 27, 50	Thomas Cemetery	Western Port Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 27/50	G. Caylinbaker M.D.	E. J. Boal	Western Port Md.

RECEIVED
SEP 5 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

08542

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

T

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
LENGTH OF STAY (In this place): 63 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt.Savage
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Joseph	Naughton	Aug	5	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	White	single	5-17-1887	63 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer, retired	Brick Plant	Mt. Savage, Maryland.	U.S.A.

13. FATHER'S NAME: Thomas Naughton

14. MOTHER'S MAIDEN NAME: Mary Crowley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
yes. W.W.I	214-01-0071	Geneieve Naughton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic endocarditis — about 2 years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Rheumatic Heart

4164
92c

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.		Cumberland, Md.	Aug. 5-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8-8-1950	St. Patricks	Mt. Savage,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-5-50	Veronica McDermott	J. R. Durst,	Frostburg, Md.

98827

RECEIVED
AUG 9 1960
BUREAU V. S.

DR. TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07847

1. PLACE OF DEATH
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 36 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CORRIGANVILLE
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) LEONARD (Middle) D. (Last) PARKER

4. DATE OF DEATH: (Month) AUGUST (Day) 22, (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOW

8. DATE OF BIRTH: OCT. 26 18[illegible]

9. AGE last birthday: 81 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: House Wife

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DICKERSON, JOHN W.

14. MOTHER'S MAIDEN NAME: Tola Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocardosis — Interval Between Onset and Death: 5 yrs.

422.2

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

938

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ulcerative Pyoderma of Skin - Generalized 2 mo

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1944, to Aug 22, 1950, that I last saw the deceased alive on Aug 22, 1950, and that death occurred at 10:05P m., from the causes and on the date stated above.

SIGNATURE: John A Topper (Degree or title) ADDRESS: Hyndman Pa. DATE SIGNED: 8/23/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Aug 25 1950
NAME OF CEMETERY OR CREMATORY: Lebanon Cemetery
LOCATION (City, town, or county) (State): Pickaway Monroe Co W. Va.

DATE REC'D BY LOCAL REG.: Aug 24, 1950
REGISTRAR'S SIGNATURE: Walter L. Fantz M.D.

24. FUNERAL DIRECTOR / ADDRESS: O. F. Sharpless, Blaine, W. Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-AT5

RECEIVED
AUG 29 1950
BUREAU V. S

DR. VAN ORMER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07848

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 27 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CRELLIN
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HOWARD	C	PHARES	8	7	19 50

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	SINGLE	JULY 2, 1889	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Office Worker	Coal Business	WEST VIRGINIA	USA.

13. FATHER'S NAME: ALFRED PHARES

14. MOTHER'S MAIDEN NAME: IDA MAE GODDIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hypertensive & Coronary Heart Disease	2 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes Mellitus	
	(c) Gen. arteriosclerosis	

260 X
61

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Jan 1948, 19..., to Aug 7, 1950, that I last saw the deceased alive on 7 Aug, 1950, and that death occurred at 8:55 P.M. from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Dr. Alfred V. Van Ormer		Cumberland, Md.	7 Aug. 50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 10, '50	Maple Wood Cemetery	Elkins, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 8, 1950	Miles L. Lantz, M.D.	Kummer Funeral Home	Elkins, W. Va

49677

RECEIVED
AUG 15 1950
BUREAU V. S

Within corporate limits.

DR. JACOBSON

07849

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,
LENGTH OF STAY (in this place) 66 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CORRIGANSVILLE
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) CLAIR (Middle) E. (Last) PORTER

4. DATE OF DEATH (Month) AUG. (Day) 24 (Year) 1950

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH JAN. 8, 1933
9. AGE last birthday 17 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT
10b. KIND OF BUSINESS OR INDUSTRY School
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ELMER A. PORTER
14. MOTHER'S MAIDEN NAME HAZEL GARLICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of rectum — INTERVAL BETWEEN ONSET AND DEATH 1948

154X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

46d

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 11-9-48
19b. MAJOR FINDINGS OF OPERATION Tumor mass in pelvis surrounding iliac vessels
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 20 1948, to Aug 24, 1950, that I last saw the deceased alive on Aug 24, 1950, and that death occurred at 11:00 A.m., from the causes and on the date stated above.

SIGNATURE Samuel Jacobson (Degree or title) Md ADDRESS 50 Pershing St Cumb Md DATE SIGNED 8/25/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug 27, 1950
NAME OF CEMETERY OR CREMATORY Temple Cem.
LOCATION (City, town, or county) White Oak (State) Pa

DATE REC'D BY LOCAL REG. Aug. 26, 1950
REGISTRAR'S SIGNATURE Winter L. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc., ADDRESS Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 29 1950
BUREAU V. S

Within corporate limits

07850

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 209 5th St.,

3. NAME OF DECEASED (Type or Print) (First) CHARLES (Middle) WILLIAM (Last) ROBISON
4. DATE OF DEATH (Month) Aug. (Day) 18, (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Sept. 29, 1891
9. AGE last birthday 58 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer
10b. KIND OF BUSINESS OR INDUSTRY Queen City Brewery
11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Joshua Robison
14. MOTHER'S MAIDEN NAME Mary Alice Sinnett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 214-05-4980
17. INFORMANT AND ADDRESS Frederick W. Robison Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary occlusion
(b) Cardiac failure
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 1 wk.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-15-, 1950, to 8-18, 1950, that I last saw the deceased alive on 8-18, 1950, and that death occurred at 1:25 P. m., from the causes and on the date stated above.

SIGNATURE Johnna Dyer, M.D. (Degree or title) ADDRESS 247 Va Ave DATE SIGNED 8-19-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 8/21/50
NAME OF CEMETERY OR CREMATORY St. Ambrose
LOCATION (City, town, or county) (State) Cresaptown, Md.

DATE REC'D BY LOCAL REG. Aug. 20, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

356 XO

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M I T

VS. A15

RECEIVED
AUG 29 1950
BUREAU

DR. VAN ORMER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07851

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD | LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA — COUNTY Grant
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PETERSBURG,
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) RAYMOND (Middle) D. (Last) SECRIST

4. DATE OF DEATH: (Month) AUGUST (Day) 23 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: DEC. 21, 1906

9. AGE last birthday: 44 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager

10b. KIND OF BUSINESS OR INDUSTRY: Chicken Hatchery

11. BIRTHPLACE (State or foreign country): Grant Co. West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SOLOMON, SECRIST

14. MOTHER'S MAIDEN NAME: ANN SCHELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 236-14-6809

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X Immediate cause (a) Cerebral Hemorrhage — 1 week

830 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 Aug 50, 19..., to 23 aug 50, 19..., that I last saw the deceased alive on 23 aug, 19 50, and that death occurred at 6:50 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

W. Alfred Van Ormer — Cumberland, Md — 24 aug 50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 8/26/50 | NAME OF CEMETERY OR CREMATORY Maple Hill | LOCATION (City, town, or county) Petersburg | (State) W Va

DATE REC'D BY LOCAL REG. Aug 25, 1950 | REGISTRAR'S SIGNATURE Mike L. Nanty M.D. | 24. FUNERAL DIRECTOR Earl Bush | ADDRESS Petersburg W Va

By Roscoe Hackerman 156VV

RECEIVED
AUG 29 1950
BUREAU V. I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07852

CERTIFICATE OF DEATH

6

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 4 mos.
HOSPITAL OR INSTITUTION (If not in either, give STREET ADDRESS) County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Alleg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland.
STREET ADDRESS (If rural, give location) 124 Oak St

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) (Last) Sheets

4. DATE OF DEATH (Month) Aug (Day) 29 (Year) 1950

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH June 5-1862 | 9. AGE last birthday 88 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | 10b. KIND OF BUSINESS OR INDUSTRY Private home | 11. BIRTHPLACE (State or foreign country) Piedmont. W. Va. | 12. CITIZEN OF WHAT COUNTRY Usa.

13. FATHER'S NAME Geo F Sheets | 14. MOTHER'S MAIDEN NAME Eleanor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT AND ADDRESS Allegany County Infirmary

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial failure	24 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	4 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4 20.1
94a

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 08, 1950, to Aug 29, 1950, that I last saw the deceased alive on Aug. 29, 1950, and that death occurred at 1 15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Arthur F. Jones M. D. | 110 S. Centre St. | Aug. 29, 1950

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE OF DEATH Aug 31-50 | NAME OF CEMETERY OR CREMATORY Philos Cemetery | LOCATION (City, town, or county) (State) Westernport. Md.

DATE REC'D BY LOCAL REG. Aug. 31, 1950 | REGISTRAR'S SIGNATURE Wentz K. Kantz M.D. | 24. FUNERAL DIRECTOR ADDRESS ~~Harold Teed Corbett Piedmont WVa~~ E. S. Beal, Westernport, Md.

VS. A15

RECEIVED
SEP 6 1950
BUREAU V. S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07853

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg Md; MARYLAND; LENGTH OF STAY (in this place) 35 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 132 Hill Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 132 Hill St. Frostburg

3. NAME OF DECEASED (Type or Print): (First) Eva (Middle) Quindora (Last) Sperry

4. DATE OF DEATH: (Month) 8 (Day) 21 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 4/22/1898

9. AGE last birthday: 52 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Acme, Pa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Howard

14. MOTHER'S MAIDEN NAME: Elizabeth Griffin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Harry Sperry (Husband) 132 Hill St. Frostburg

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Uremic poisoning	72 to 96 hrs
447X 97 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Malignant hypertension (over 300 plus 180)	1 year plus
	(c) Advanced Arteriosclerosis	3 to 4 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 19 49, to 21 Aug, 19 50, that I last saw the deceased alive on 21 Aug, 19 50, and that death occurred at 1:55 A.D.S. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John B. Davis, M.D. Frostburg, Md. 8/21/50.

23. BURIAL, CREMATION, REMOVAL (Specify): Buried

DATE THEREOF: 8/23/50

NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

LOCATION (City, town, or county) (State): Frostburg, Md

DATE REC'D BY LOCAL REG. 8-22-50

REGISTRAR'S SIGNATURE: Mrs. Dailey N. Roe

24. FUNERAL DIRECTOR: Jacob Hofer ADDRESS: 23 E. Main, Frostburg Md

RECEIVED
AUG 24 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07854

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 10 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 145 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural give location) 145 Bedford St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	William	Spiker	Aug.	11	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	Married	Sept.10-1871	78 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired restaurant owner.		Berkley Spring W.Va .	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harrison Spiker	Rebecca Dawson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	None	Mrs Ralph Herbert, Youngstown. Ohio

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary occlusion	at once
94a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
		(c)	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.	Cumberland, Md.	Aug.11-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 15/50	Hyndman Cemetery	Hyndman, Penna.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 15, 1950	Winter R. Mintz, M.D.	William H. Kight,	Cumberland, Md.

15671

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

RECEIVED
AUG 22 1950
BUREAU V. S

07855

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 5

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresaptown
LENGTH OF STAY (In this place) 5 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Amcelle Acres

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresaptown
STREET ADDRESS (If rural give location) Amcelle Acres

3. NAME OF DECEASED (Type or Print) (First) Virginia (Middle) (Last) Thompson

4. DATE OF DEATH (Month) Aug. (Day) 22 (Year) 1950

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Nov. 29, 1860
9. AGE last birthday 89 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Mouth of Seneca, W. Va.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Tobias Raines
14. MOTHER'S MAIDEN NAME Betty Harper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Rosie A. Raines, Rt. 5, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
422.2	Immediate cause	(a) Acute cardiac failure due to	at once
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocarditis	?
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) Herbert V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Aug.23-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 8/25/50
NAME OF CEMETERY OR CREMATORY Thompson Cemetery
LOCATION (City, town, or county) (State) Riverton, W. Va.

DATE REC'D BY LOCAL REG. Aug. 23, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 25 1950
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07856

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) John (Middle) N. (Last) Thrasher

4. DATE OF DEATH: (Month) August (Day) 9 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec 1, 1887

9. AGE last birthday: 62 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY: Georges Creek Coal Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Thrasher

14. MOTHER'S MAIDEN NAME: Mary Sheppard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

16. SOCIAL SECURITY NO. (If yes, give war or dates of service): 213-01-8822

17. INFORMANT: John N. Thrasher Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.1 **Immediate cause**	(a) Coronary occlusion	1 hour
94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	5 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Peptic ulcer — 2 years

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 19 49, to Aug 9, 19 50, that I last saw the deceased alive on August 9, 1950, and that death occurred at 5 15 p.m., from the causes and on the date stated above.

SIGNATURE: Adolph Wolfermay | (Degree or title) M.D. | ADDRESS Frostburg | DATE SIGNED 8-10-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF Aug. 12-1950 | NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park | LOCATION (City, town, or county) Frostburg, (State) Md.

DATE REC'D BY LOCAL REG. 8/11/50 | REGISTRAR'S SIGNATURE: Jeannette M Bool | 21. FUNERAL DIRECTOR: M. Eichhorn | ADDRESS: Lonaconing, Md.

30877

RECEIVED
AUG 17 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07857

CERTIFICATE OF DEATH

Reg. Dist. No. 4

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 439 Columbia St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 439 Columbia St.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) George (Last) Treiber

4. DATE OF DEATH: (Month) August (Day) 17 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 22, 1878

9. AGE last birthday: 72 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Kelly Springfield Tire

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Howard Treiber

14. MOTHER'S MAIDEN NAME: Mary E Werner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-03-7551

17. INFORMANT AND ADDRESS: Mrs. Lillian McKenzie, Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure -	1 Wk.
196X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma - left jaw - spread to Stomach	?
452	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION; 19b. MAJOR FINDINGS OF OPERATION; 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify); PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY; (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.; INJURY OCCURRED While at Work ☐ Not While At work ☐; HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 7, 1950, to Aug 17, 1950, that I last saw the deceased alive on Aug 17, 1950, and that death occurred at 8 50 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Lambert Jacobsen MD ADDRESS 50 Bishop St Cumberland Md DATE SIGNED 8/19/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial; DATE THEREOF 8/20/50; NAME OF CEMETERY OR CREMATORY Rose Hill Cem.; LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REG. Aug. 19, 1950; REGISTRAR'S SIGNATURE Winter K. Wantz M.D.

24. FUNERAL DIRECTOR; ADDRESS LOUIS STEIN, INC 32635 Cumberland, Maryland

RECEIVED
AUG 22 1960
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07858

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
MARYLAND — LENGTH OF STAY (in this place): 14 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 753 Maryland Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Nancy	Jane	Van Sickle	Aug	28	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	Nov 8 1886	63 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	at Home	Friendsville Md.	U.S.

13. FATHER'S NAME: Isaac Turney

14. MOTHER'S MAIDEN NAME: Frances Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: James J. Van Sickle St-Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial failure	
420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Heart Disease	15 yrs.
93d	(c) Generalized arteriosclerosis	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
None				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
None			m.		

22. I hereby certify that I attended the deceased from Aug 18, 1950, to Aug. 28, 1950, that I last saw the deceased alive on Aug. 28, 1950, and that death occurred at 6:10 P m. from the causes and on the date stated above.

SIGNATURE (Degree or title): James H. Hallman MD — ADDRESS: 300 Decatur St. Cumberland Md — DATE SIGNED: 8/29/1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Aug 31 1950	Oakland Cemetery	Oakland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 30, 1950	Walter K. Hartz, M.D.	John J. Hafer	Cumberland Md.

VS. A15

RECEIVED
SEP 6 1950
BUREAU

Within co[illegible] limits

DR. DYER

Mail to Cumb'd. Health Dept.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07859

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, LENGTH OF STAY (in this place): 4 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: McCOOLE
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) WILLIAM	(Middle) H	(Last) WARD	4. DATE OF DEATH	(Month) 8 (Day) 8 (Year) 50
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED	8. DATE OF BIRTH: MARCH 31, 1859	9. AGE last birthday: 91 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner - Retired	10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines	11. BIRTHPLACE (State or foreign country): ~~MARYLAND~~ Marietta, Ohio	12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME: WARD William	14. MOTHER'S MAIDEN NAME: Anne Benford				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
434.3 Immediate cause	(a) Pulmonary Embolism	24 hrs
46 e Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardiac Decompensation	48 hrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Annular Carcinoma colon — unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-4-, 1950, to 8-8-, 1950, that I last saw the deceased alive on 8-8-, 1950, and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE: John A. Dyer, (Degree or title) M.D. ADDRESS: 247 Va Ave DATE SIGNED: 8-9-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: Aug 11, 1950	NAME OF CEMETERY OR CREMATORY: Bloomington Cemetery	LOCATION (City, town, or county) (State): Garrett Co. Md.
DATE REC'D BY LOCAL REG.: Aug. 9, 1950	REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR: E. S. Boal	ADDRESS: Westernport, Md.

45442

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

153X

VS A15

RECEIVED
AUG 15 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07860

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 15 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural give location) 617 SedgewickSt.

3. NAME OF DECEASED (Type or Print): (First) Charles; (Middle) A.; (Last) Welsh

4. DATE OF DEATH: (Month) Aug.; (Day) 13; (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: July-1-1888

9. AGE last birthday: 62 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steward

10b. KIND OF BUSINESS OR INDUSTRY: W.O.W.Club.

11. BIRTHPLACE (State or foreign country): Grafton, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Micheal J.Welsh

14. MOTHER'S MAIDEN NAME: Margaret Flanagan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 217-10-6562

17. INFORMANT: Charles Welsh, Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X **Immediate cause** (a) Acute cardiac failure — Interval between onset and death: at once

131a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardio-vascular-renal disease — about 2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Dey) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland,Md. Aug.14-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 8-16-1950

NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Aug 15, 1950

REGISTRAR'S SIGNATURE: Hunter R Crantz M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

73299

RECEIVED
AUG 22 1950
BUREAU W. S

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07861

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Cumberland
LENGTH OF STAY (In this place) 20 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D.#3 BedfordRoad

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland
STREET ADDRESS (If rural give location) R.F.D.#3 Bedford Road

3. NAME OF DECEASED (Type or Print) (First) Herbert (Middle) John (Last) Wentz
4. DATE OF DEATH (Month) Aug. (Day) 4 (Year) 1950
5. SEX Male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Nov.30-1876
9. AGE last birthday 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk-Bennett
10b. KIND OF BUSINESS OR INDUSTRY Transfer Co.
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Wentz
14. MOTHER'S MAIDEN NAME Anna Anderson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs.Norma Wentz

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure due to	at once
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocarditis	about 2 yrs.
93d	(c) Arteriosclerosis	?

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. H. V. Deming M.D. (Degree or title) ADDRESS Cumberland,Md. DATE SIGNED Aug.5-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug 7 1950
NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery
LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. Aug. 7, 1950
REGISTRAR'S SIGNATURE Writes R. Wantz, M.D.
24. FUNERAL DIRECTOR ADDRESS William H. Kight, Cumberland, Md.

49650

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 15 1950
BUREAU OF S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

07862

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
MARYLAND
LENGTH OF STAY (in this place): 67 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Dead on arrival at Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Cumberland Valley--Head
STREET ADDRESS (If rural give location): R.F.D.#3 Valley Road.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Albert	Wiant	Aug.	3	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	Sept.1-1882	67 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant	Grocery	Cumberland Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James A. Wiant	Elizabeth Wolfe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
NO	214-10-5315	James A. Wient Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Coronary sclerosis	?
(c)		

420.1
94 a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: naturol causes* ☒, *occident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.	Cumberland, Md.	Aug.3-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 7 1950	Hill Crest Cemetery	Cumberland, Maryland.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 7, 1950	Walter R. Bantz, M.D.	William H. Kight, Cumberland, Md.	

15661

RECEIVED
AUG 15 1950
BUREAU V. I.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

07863

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; MARYLAND; LENGTH OF STAY (In this place): 28 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing; STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Bernadette (Last) Winner

4. DATE OF DEATH: (Month) Aug (Day) 28 (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: June 29-1927

9. AGE last birthday: 23 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): nursing, in Dr Zimmermans Office

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bernard F. Winner

14. MOTHER'S MAIDEN NAME: Katherine Rafferty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

252.0 Immediate cause (a) Acute cardiac failure due to — at once

630 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Thyrotoxicosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8-28-1950

19b. MAJOR FINDINGS OF OPERATION: Toxic goiter, adhesions, also enlarged thymas

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. V. Deming M.D. N. V. Deming M.D. Cumberland, Md. Aug 28-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF: August 31, 50 NAME OF CEMETERY OR CREMATORY: St Marys Cemeterey LOCATION (City, town, or county) (State): Lonaconing, Md

DATE REC'D BY LOCAL REG.: Aug. 29, 1950 REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: M. Eichhorn ADDRESS: Lonaconing-, Md.

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RECEIVED
SEP 6 1950
BUREAU V. S.